BEFORE THE ARIZONA MEDICAL BOARD

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| In the Matter of<br>**RAJIV JETLY, M.D.**<br>Holder of License No. 29064<br>For the Practice of Allopathic Medicine<br>In the State of Arizona | Case No. MD-07-0707A<br>**CONSENT AGREEMENT FOR LETTER OF REPRIMAND** |

## CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Rajiv Jetly, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

RAJIV JETLY, M.D.

DATED: 25 June 2008

## FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 29064 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0707A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a seventy-five year-old female patient ("TW").

4. On December 13, 2001, TW was a resident at a nursing care facility when Respondent became her primary care physician. TW weighed 124 pounds and had poor oral intake. Nursing notes documented that TW had ill-fitting denture plates that the family was addressing. Respondent saw TW repeatedly in December 2001, but he did not document an examination of her oral cavity or make notations of her weight loss. A rehabilitation note of December 28, 2001, indicated TW could not swallow for twenty-four hours and that her weight decreased to 117 pounds. Respondent again did not examine her oral cavity.

5. On January 3, 2002, Respondent verbally ordered a segment type evaluation for dysphagia. Further verbal orders recommended health shakes, supplements and a dietary evaluation due to TW's poor nutritional intake. Respondent again did not examine TW. On January 11, 2002, Respondent was contacted and informed that TW was weak, unable to stand and drooling greenish-yellow drainage.

6. On January 11, 2002, TW was transferred to the emergency room weighing 112.4 pounds and she was started on intravenous (IV) fluids and IV antibiotics. Respondent performed an oral examination that indicated TW had a broken right lower

incisor, discharge in the buccal space and a dime-sized ulceration to the tongue. Chest x-rays demonstrated a lingular infiltrate.

7. On January 12, 2002, Respondent ordered a swallow evaluation and TW's oral cavity was noted to be covered with open sores. TW also had delayed swallowing and aspiration of thin and pureed liquid. Respondent ordered placement of a nasogastric (NG) tube and chest x-ray for pneumonia status and tube placement. The chest x-ray demonstrated that the feeding tube extended down the trachea through the right mainstem bronchus, tip in the region of the posterior sulcus of the lung with no pneumothorax. The NG tube was removed and replaced. A repeat chest x-ray demonstrated that the NG tube had extended down the trachea, entered the left mainstem bronchus and then looped around the left lung. The report also indicated that TW had developed bilateral pneumothoraces. Respondent ordered a radiology consultation to review TW's chest x-rays and verify tube placement; however, TW developed chest pains and her lungs had diminished breath sounds. Respondent placed TW on a 100% non-rebreather mask and transferred her to the intensive care unit where she experienced cardiac arrest and subsequently died. The radiologist arrived to give his formal x-ray interpretation and verify the tube placement; however, TW had died.

8. The standard of care requires a primary care physician to fully assess and evaluate a patient who has had continued weight loss while residing at a nursing care facility.

9. Respondent deviated from the standard of care because he did not fully evaluate TW for her continued weight loss.

10. The standard of care requires a physician to perform and document a complete examination of the oral cavity, including gag reflex of a patient noted on rehabilitation screening to be unable to swallow for twenty-four hours.

11. Respondent deviated from the standard of care because he did not perform and document a complete examination of TW's oral cavity, including a gag reflex.

12. The standard of care requires a physician to have an emergent surgical consultation for chest tube placement in a patient with new bilateral pneumothoraces following attempted NG placement, chest pain and severe hypoxia.

13. Respondent deviated from the standard of care because he did not obtain an emergent surgical consultation for chest tube placement after TW developed post-procedural pneumothoraces, chest pain and respiratory distress.

14. Respondent's failure to properly evaluate TW's clinical status led to her suffering continued weight loss, developing oral ulcerations and her death. TW's poor oral condition may have contributed to her aspiration and the lingular pneumonia.

## CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

## ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to properly evaluate a patient with persistent weight loss, including an oral cavity examination and for failure to obtain a surgical consultation for a patient with new bilateral pneumothoraces, chest pain and hypoxia after a procedure.

2. This Order is the final disposition of case number MD-07-0707A.

DATED AND EFFECTIVE this 8th day of August, 2008.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 8th day of August, 2008 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 8th day of August, 2008 to:

Rajiv Jetly, M.D.
Address of Record

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Investigational Review